

## Birth Hospital Clinical Summary

*It is very important to attend your follow-up appointments.  
Bring this form with you to any follow-up appointments or hospitalizations.*

<b>Next OB Appointment:</b>		<b>Next Pediatric Appointment:</b>	
<b>Patient Name</b>			
<b>Date of Delivery</b>			
<b>Hospital</b>		<b>Phone Number</b>	
<b>OB Clinician Name</b>		<b>Phone Number</b>	
<b>Pediatrician Name</b>		<b>Phone Number</b>	
<b>Clinical Summary</b>			
<b>Type of Birth</b>	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Comments:		<b>Blood Type</b>
			<b>Postpartum Hemoglobin</b>
<b>Diagnosis (list all)</b>			
<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>			
<b>Pregnancy Outcome</b>			
<b>Baby</b>	<b>Gestational Age (in weeks)</b>	<b>Birthweight</b>	<b>Length</b>
<b>Surgery</b>	<i>Date</i>		
	<i>Type</i>		
<b>Blood Transfusion</b>	<i>Type of Blood Products</i>	<input type="checkbox"/> Red Blood Cells <input type="checkbox"/> Platelets <input type="checkbox"/> Plasma	
	<i>Number of units</i>	___ Red Blood Cells   ___ Platelets   ___ Plasma	
<b>Imaging Tests</b>	<input type="checkbox"/>	<i>Date</i>	
	Yes	<i>Type</i>	
	<input type="checkbox"/> No	<i>Result</i>	
<b>Interventional Radiology</b>	<input type="checkbox"/>	<i>Date</i>	
	Yes	<i>Type</i>	
	<input type="checkbox"/> No	<i>Result</i>	
<b>Medical Treatments</b>			
<b>Notes</b>			